



**InsureKidsNow.gov**  
Connecting Kids to Coverage

## Summary of Benefits for North Carolina, MEDICAID

### Children's Dental Services

#### Preventive Services

|  | Is the service Covered? |                               |    | Frequency    | List any service-specific limitations                                    |
|--|-------------------------|-------------------------------|----|--------------|--|
|  | Yes                     | Only with prior authorization | No |              |  |
| Cleanings  | X                       |                               |    | 2 x year     |  |
| Fluoride treatments (including fluoride varnishes) | X                       |                               |    | 2 x year     |  |
| Sealants (list any tooth-specific limits)          |                         |                               |    | 1 x lifetime | 6-15 years old (Children younger than 6 years are not eligible for NCHC) |
| Space maintainers                                  | X                       |                               |    |              |  |



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### Diagnostic Services

|                            | Is the service Covered? |                               |    | Frequency | List any service-specific limitations   | Recommended age of first visit? |
|----------------------------|-------------------------|-------------------------------|----|-----------|---|---------------------------------|
|                            | Yes                     | Only with prior authorization | No |           |   |                                 |
| <b>Dental examinations</b> |                         |                               |    |           |   |                                 |
|                            | X                       |                               |    | 2 x year  |   | 6 months                        |
| <b>X-Rays</b>              |                         |                               |    |           |   |                                 |
| Bitewing                   | X                       |                               |    |           | Coverage limitations are one per 12-month period, D0270 - Bitewing (single film), D0272 - Bitewing (two films), D0273 - Bitewing (three films), D0274 - Bitewing (four films), D0277 - Vertical Bitewings (7/8 films), Coverage limitations are one per 5-year period D0210 - Intraoral complete series (including bitewings and panorex), D0330 - Panorex, D0340 - Cephalometric |                                 |
| Full Mouth                 |                         |                               |    |           |   |                                 |
| Panoramic                  |                         |                               |    |           |   |                                 |



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### Treatment Services

|   | Is the service Covered? |                               |    | Frequency | List any service-specific limitations                                   | Criteria for coverage |
|---|-------------------------|-------------------------------|----|-----------|---|-----------------------|
|   | Yes                     | Only with prior authorization | No |           |   |                       |
| <b>Fillings</b>                         |                         |                               |    |           |   |                       |
| Silver amalgam                          | X                       |                               |    |           |   |                       |
| Tooth colored composite                 | X                       |                               |    |           |   |                       |
| <b>Crowns/tooth caps</b>                |                         |                               |    |           |   |                       |
| Stainless steel crowns                  | X                       |                               |    |           |   |                       |
| Metal (only) crowns                     |                         | X                             |    |           |   |                       |
| Metal/porcelain crowns                  |                         | X                             |    |           |   |                       |
| Porcelain (only) crowns                 |                         | X                             |    |           |   |                       |
| <b>Root Canals (endodontics)</b>        |                         |                               |    |           |   |                       |
| Root canals on baby teeth (pulpotomies) | X                       |                               |    |           |   |                       |
| Root canals on permanent teeth          | X                       |                               |    |           | allowed for anterior teeth 6-11 and 22-27 and molars 3, 14, 19, 30 only |                       |
| <b>Gum (periodontal) therapy</b>        |                         |                               |    |           |   |                       |
|   |                         |                               | X  |           |   |                       |



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|-------------------------|-------------------------|-------------------------------|----|-----------|---|-----------------------|
|                         | Yes                     | Only with prior authorization | No |           |   |                       |
| <b>Dentures</b>         |                         |                               |    |           |   |                       |
| Partial dentures        |                         |                               | X  |           |   |                       |
| Complete dentures       |                         |                               | X  |           |   |                       |
| Bridges                 |                         |                               | X  |           |   |                       |
| <b>Orthodontics*</b>    |                         |                               |    |           |   |                       |
| Retainers (orthodontic) |                         |                               | X  |           |   |                       |
| Braces                  |                         |                               | X  |           |   |                       |
| <b>Oral surgery</b>     |                         |                               |    |           |   |                       |
| Simple extractions      | X                       |                               |    |           |   |                       |
| Surgical extractions    | X                       |                               |    |           |   |                       |
| Care of abscesses       |                         | X                             |    |           |   |                       |
| Cleft palate treatment  |                         | X                             |    |           |   |                       |
| Cancer treatment        |                         | X                             |    |           | (Note: Removal of teeth is covered, but replacement is not) |                       |
| Treatment of fractures  |                         | X                             |    |           |   |                       |
| Biopsies                |                         | X                             |    |           |   |                       |



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|---|-------------------------|-------------------------------|----|-----------|---------------------------------------|--|
|   | Yes                     | Only with prior authorization | No |           |                                       |  |
| Treatment of jaw joint problems (TMJ)         |                         |                               |    |           |                                       |  |
|   |                         | X                             |    |           | Y - for surgery and splint therapy    | Diagnostic tests, x-rays, office visit records |
| Emergency room services provided by a dentist |                         |                               |    |           |                                       |  |
|   |                         |                               | X  |           |                                       |  |



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|-----------------------------|-------------------------|-------------------------------|----|-----------|---------------------------------------|---|
|                             | Yes                     | Only with prior authorization | No |           |                                       |   |
| Inpatient Hospital Services |                         |                               |    |           |                                       |   |
|                             |                         |                               | X  |           |                                       | Not covered under dental benefit. Hospital coverage for dental surgery may be covered under the medical benefit: Benefits are provided for hospital and ambulatory surgical center services for care related to dental surgery when it is necessary for the care to be received in a hospital setting |
| Anesthesia                  |                         |                               |    |           |                                       |   |
| General anesthesia          |                         |                               |    |           |                                       |   |



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|------------------------------------|-------------------------|-------------------------------|----|-----------|---------------------------------------|-----------------------|
|                                    | Yes                     | Only with prior authorization | No |           |                                       |                       |
| Intravenous conscious sedation     |                         |                               |    |           |                                       |                       |
| Non-intravenous conscious sedation |                         |                               |    |           |                                       |                       |
| Analgesia (nitrous oxide)          |                         |                               |    |           |                                       |                       |

\* When this information is posted on the Insure Kids Now website, we will include a special note for orthodontic services explaining that parents and caretakers should work with their child's orthodontist to ensure that the treatment and payment terms and conditions are clear at the outset of treatment (for example, what happens in the case of a child who becomes ineligible for Medicaid or CHIP while he or she is undergoing orthodontic treatment?).